order today. I think we really brought out a lot of good points.

LONG-TERM CARE JEOPARDIZED

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Virginia [Mr. MORAN] is recognized for 5 minutes.

Mr. MORAN. Mr. Speaker, we all know that Americans are living longer, and they are living longer with chronic and often incapacitating illness. For many of them, nursing home care is the only option. It is a difficult and painful choice, not one that any individual or family would take lightly, particularly given the cost of nursing home care. Mr. Speaker, in northern Virginia, in the district I represent, the average cost of nursing home care is $45,000 per year.

So the State of Virginia has been very stringent in determining Medicaid eligibility. That is why this is relevant to the discussion that just took place. Without the cuts to the Virginia Medicaid program, Virginia would be providing 54,000 individuals with access to home and community-based care, 24,300 nursing home recipients, and 2,300 individuals in intermediate care facilities for the mentally retarded.

But in the face of the Medigrant Program, which caps Medicaid long-term care spending as soon as 1996, next year, $968 million, or 27 percent of the budget for long-term care in the State of Virginia by the year 2002 would be cut. That translates into a reduction of 9,000 people who would no longer be eligible for assistance next year, and 37,000 nursing home residents who would no longer be eligible for care in 2002. We have to ask ourselves, where would these people end up?

In 1987, President Ronald Reagan signed into law Federal standards for nursing homes. This was a direct consequence of the in ability of the States to establish standards and monitor and enforce them. The newspapers were filled with horrible accounts of abuse of our Nation's seniors. That is why President Reagan responded to the abuse that was taking place across the country.

This Medigrant Program turns back the clock. It turns the responsibility of establishing, monitoring, and enforcing nursing home standards back to the States. Clearly President Reagan would not have usurped that responsibility if there were any alternative way of ensuring quality care for our Nation's seniors.

All families with members needing long-term care have been paying for many years to care for their parent or child at home. In the end, their ability to care for that person, both physically, emotionally or financially, runs out.

In my district, the eligibility requirements to receive Medicaid assistance for long-term care are already very stringent. Thirty-four percent of all Medicaid dollars are spent on long-term care assistance. This is considerably lower than the national average. But once an individual is determined to be eligible, the State does not come after the adult children to pay for nursing home care.

This legislation included in the 7-year balanced budget plan, the Medigrant legislation, empowers States to require payments from adult children if the family income is above the State median, regardless of other financial obligations. Governor Bush said, and I want to quote him, ''I plan to go after all adult children of nursing home residents.''

Many allude to middle-class seniors divesting their fortunes in order to qualify for Medicaid, but the anecdotes do not add up. The GAO found in a 1993 study that less than 10 percent of all Medicaid applicants had transferred their assets in order to qualify for assistance, but even that did not result in increased Medicaid spending. Furthermore, Congress changed the law in 1993, requiring that Medicaid eligibility could not be considered within 3 years of the asset transfer.

In 1993, Congress required States to recover from the estate of deceased Medicaid beneficiaries. It did not require the seizure of homes or businesses, and it even prohibited such actions if the home was being lived in by a spouse. Current law also protects against liens and estate recovery while dependent children are living.

But Medigrant repeals these protections. The Medigrant bill empowers States to pursue family homes to recover long-term care expenses, even if those homes are currently occupied by families members. All that protection is repealed.

Mr. Speaker, I will not take any more time. There is so much more that I could say about this. It is all of a critical nature, because we are taking away the security that is currently available to families who desperately need it.

☐ 1730

We are enabling States to go after homes, to seize assets, no matter how impoverished the spouse might be, to take away the standards that President Reagan put into place to protect our senior citizens. This goes far beyond the dollars and cents.

I think this is a profound erosion of the kind of security that Americans have come to, and should be able to, expect.

I thank the Chair for the opportunity to express this on the floor today, and I would hope we are going to turn this back.

The Medigrant Program repeals protection for the spouses and children of nursing home residents. Medigrant gives States the flexibility to deny coverage. Income and resource set-asides for the spouse of a nursing home resident have been maintained in Medigrant, but these are only available after a resident has been found eligible for coverage.

Under Medigrant, there is no assurance of coverage even if you meet income and resource standards; no required fair hearing to challenge a determination of noncoverage; no protection against having a lien placed on the home; no requirement for clarity about what is included in the Medigrant rate; no requirement that Medigrant cover a specific set of services; and no allowance for putting aside money for a disabled child.

I have been told that Medigrant requires States to set-aside considerable resources for nursing care services. Although the amount Medigrant requires to be set aside for the elderly is based upon expenditures for current nursing home services, nothing in law requires such services to be offered. The funds set aside are considerably less than what Medicaid sets aside today. In fact, a number of studies have suggested that the first cuts will be made on community and home based long-term care, forcing disabled and frail elderly to apply for the much more costly nursing home care.

Why? Because the nursing home industry is much stronger and financially able to lobby for dollars than the burgeoning community based care community.

The block grants are capped, regardless of economic or demographic changes. The rate of growth will not keep pace with inflation or increased use due to an aging population. The bill, on average, increase spending at 5.2 percent a year, while long-term care spending will increase at about 9.5 percent a year. Virginia is particularly hard hit because of the aging of the population. Residents older than 65 years will increase from 7.3 to 15.7 percent of the total population. In the next 15 years, there will be five times as many Virginians older than 75 and nine times as many Virginians older than 85 years as there were in 1960.

This Nation made a commitment 30 years ago to investing in medical technology and medical assistance to extend and improve the lives of senior citizens. Assistance for long-term care is the humane extension of medical intervention and assistance. Those who seek long-term care are seeking to complete their lives with dignity, as independently as possible and certainly, not as a financial burden on their children or grandchildren. The Medigrant bill takes away this dignity from those who need long-term care and from their families.

HOW THE MEDICAID CUTS AFFECT VIRGINIA

Issue: The current proposed block grant for the Medicaid program relies on a formula which rests on the current federal match now received by each state. This unfairly penalizes Virginia, because it locks in current funding patterns among the states, regardless of need or changing demographic patterns, while high cost states that have not been efficient or judicious with their Medicaid dollars will continue to benefit at high levels of federal assistance.

Congressional proposals do little to address vast disparities in federal Medicaid grants to the states. Both lock in generous payments to some states at the expense of others. Under both plans, New Hampshire and Connecticut would get twice as much per poor person as Virginia. Under both proposals, Virginia will continue to have the seventh lowest grant per poor person in 2002. (Poor is defined as those in families earning 100% or less of the federal poverty level, which is $11,817 for a family of three in 1995).

History: Virginia has been very conservative in its determination of program eligibility and benefits; management of Medicaid dollars and beneficiaries; and in its claim on federal resources.

Virginia has the seventh lowest federal grant per person in poverty. Virginia is below the national average in state Medicaid spending per beneficiary. 75% of its Medicaid expenditures are on mandatory services and 25% are on optional services . . . this is below the national average.

(States must offer a minimum acute care benefit package to their eligible populations. They can cover other acute services at their discretion. States vary widely in their coverage of optional acute services.)

Virginia has established tight eligibility standards. Thus, although Virginia has a higher poverty rate than Connecticut, Massachusetts and Rhode Island (and closely trails New York), Virginia covers less than half of its poor residents in Medicaid, while these other states have enrolled 60–90% of their poor.

DISPROPORTATIONATE SHARE PAYMENTS TO HOSPITALS

In the early 1990's, some states aggressively pursued DSH money in order to leverage more federal dollars. DSH payments were intended to help hospitals serving high volumes of uninsured and Medicaid patients. They did this by adding money generated from hospital assessments and ''voluntary payments'' from hospitals and adding that to state funds, in order to leverage more federal matching funds, and then paid back that money to those hospitals. Until these schemes were controlled in 1993, many states received huge amounts of federal Medicaid dollars, which they spent on general state needs. Two-thirds of DSH spending is concentrated in 8 states. DSH payments to Northeast high cost states are 6–16 times higher than in Virginia.

Virginia chose not to participate in aggressively capturing DSH dollars, as they felt it was an inappropriate use of federal funds.

The proposed Medicaid block grants lock the DSH inequities into place, leaving Virginia with only a small amount of DSH funds. Those states like NH, LA, NY, CT, NJ, will continue to receive significant DSH dollars under the block grant.

DEMOGRAPHICS

The block grant does not take into consideration the changing demographic trends in Virginia. The population is aging and the percentage of older Americans moving into Virginia from other states is increasing.

By 2020, the total population of VA. will number 8.4 million, up from 6.5 million in 1990. The elderly are the fastest growing segment of the population. Residents older than 65 will increase from 7.3% to 15.7% of the total population. There will be five times as many Virginians older than 75 and nine times as many Virginians older than 85 as there were in 1960. The elderly are the heaviest users of health care; it is reasonable to assume a growing percentage of this population will become Medicaid-dependent for nursing home care and other long term care services at an increasingly high cost.

WHAT HAS THE STATE DONE TO MAXIMIZE ITS MEDICAID DOLLARS?

Virginia has implemented a number of cost containment techniques to improve ''efficiency'' of the Medicaid program. The Va. Dept. of Medical Assistance estimated in 1994 that since 1982, Virginia has realized about $217 million dollars annually in savings and cost avoidance through cost containment measures including:

Medicaid managed care

Moratorium on nursing home construction

Limits on inpatient hospital admission before non-emergency surgery

Expanded use of generic drugs

Utilization management for hospital and other services

Preadmission screening for nursing home applicants

Adult day care alternatives to nursing home placement

24-hour obstetric discharge using a home health alternative

As a result of improved efficiency, Virginia has not required continued large increases in federal matching dollars. Yet, the state will be penalized for prudent and judicious use of Medicaid money. Those states with inefficiently run programs that are high cost to the federal government, including those states that illegally garnered DSH dollars, will continue to receive the highest contribution. The current Medicaid program is flexible enough to allow Va. to receive more federal dollars as the needs and available resources change. The proposed block grant proposal bases consideration of future federal funding on current levels, regardless of each state's future needs.

What should be incorporated into the Medicaid block grant is an effort to move all states to an equitable level of federal financial support per capita. That is not unlike the policy in place for the Medicare program. When that program moved from a cost-based reimbursement to reimbursement by diagnosis-related group, formerly vastly different rates paid to providers were moved to a national rate adjusted only by the special labor costs within regions. This uniformly provides the same incentives to all states to operate efficient Medicaid programs.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. HANSEN (at the request of Mr. ARMEY), after 12:30 p.m. today, on account of personal reasons.

Mr. EMERSON (at the request of Mr. ARMEY), for today, on account of a doctor's appointment.

Ms. HARMAN (at the request of Mr. GEPHARDT), for today, on account of personal business in the district.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. DOGGETT) to revise and extend their remarks and include extraneous material:)

Mr. POSHARD, for 5 minutes today.

Ms. NORTON, for 5 minutes today.

Ms. SLAUGHTER, for 5 minutes today.

Mr. ROEMER, for 5 minutes today.

Mr. GENE GREEN of Texas, for 5 minutes today.

Mr. DOGGETT, for 5 minutes today.

Mrs. SCHROEDER, for 5 minutes today.

Mr. BROWN of Ohio, for 5 minutes today.

Ms. DELAURO, for 5 minutes today.

Mr. BENTSEN, for 5 minutes today.

Mr. FALEOMAVAEGA, for 5 minutes today.

Mr. VOLKMER, for 5 minutes today.

(The following Members (at the request of Mr. TIAHRT) to revise and extend their remarks and include extraneous material:)

Mr. GOSS, for 5 minutes today.

Mr. LEWIS of Kentucky, for 5 minutes today.

Mr. MANZULLO, for 5 minutes today.

Mr. COX of California, for 5 minutes today.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. MORAN, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. DOGGETT) and to include extraneous matter:)

Mr. BONIOR.

Mr. FRANK of Massachusetts.

(The following Members (at the request of Mr. TIAHRT) and to include extraneous matter:)

Mr. HERGER.

Mr. SAXTON.

(The following Members (at the request of Mr. ABERCROMBIE) and to include extraneous matter:)

Mr. FIELDS of Texas.

Mr. HASTERT.

Mr. RUSH.

Ms. VELÁZQUEZ.

Mr. REED.

Mr. BARRETT of Wisconsin.

Mr. POSHARD.

Mr. WILSON.

Mr. BILIRAKIS.

Mr. ROYBAL-ALLARD.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 1331. An act to adjust and make uniform the dollar amounts used in title 18 to distinguish between grades of offenses, and for other purposes; to the Committee on the Judiciary.

S. 1465. An act to extend au pair programs; to the Committee on International Relations.

ENROLLED BILLS SIGNED

Mr. THOMAS, from the Committee on House Oversight, reported that that committee had examined and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 325. An act to amend the Clean Air Act to provide for an optional provision for the reduction of work-related vehicle trips and miles travelled in ozone nonattainment areas designated as severe, and for other purposes; and

H.R. 1240. An act to combat crime by enhancing the penalties for certain sexual crimes against children.

ADJOURNMENT

Mr. ABERCROMBIE. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 5 o'clock and 31 minutes p.m.), the House adjourned until tomorrow, Friday, December 15, 1995, at 10 a.m.